NOTICE OF INABILITY TO DETERMINE LIABILITY/ REQUEST FOR ADDITIONAL TIME STATE FORM 48557 (9-97)

INSTRUCTIONS: Complete appropriate sections of this document and sign in the space below.
PLEASE TYPE OR PRINT IN INK.

PRIVACY NOTICE
***This agency is requesting disclosure of your Social Security number in accordance with IC 22-3-4-13. This disclosure is not mandatory and you will not be penalized for refusing.**

Accident Number

CLAIM INFORMATION

Name of Employer	Federal ID Number	Address of Employer	Telephone Number ( )
Name of Insurer		Insurer Claim Number	Date of Injury
Address (city, state, zip)		Telephone Number	
Name of Employee	*Social Security Number	Address of Employee	Telephone Number ( )

REQUEST FOR ADDITIONAL TIME

Notice of inability to determine liability must be made in writing and mailed to The Board and the employee not later than thirty (30) days after the employer's knowledge of the injury (IC-22-3-3-7). (Check appropriate action below.)

☐ **Request for additional thirty (30) days.**
Reasons determination cannot be made within thirty (30) days: _____

_____

Facts or circumstances necessary to determine liability: _____

_____

☐ **Request for additional time beyond thirty (30) days**
Extraordinary circumstances which have precluded determination of liability: _____

_____

Status of the investigation: _____

_____

Facts or circumstances necessary to determine liability: _____

_____

Timetable for completion of remaining investigation: _____

_____

EMPLOYER/CARRIER CERTIFICATION

Employer must sign below to certify service.

Signature of employer/carrier	
Date signed (month, day, year)	By : ☐ U.S. Mail ☐ Personal Service

Workers Compensation Board
402 W. Washington, Rm W196
Indianapolis, IN 46204-2753

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